MEMBER CERTIFICATE AND AGREEMENT

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SECTION I. DEFINITIONS

The following terms shall have the following definitions when used throughout this Agreement and throughout any other document, which shall hereafter become a part of the Contract as herein after defined in this section.

1. ***"ACUTE CONDITION"***
   A disease or symptom that is brief, severe, and quickly comes to a crisis, requiring timely medical attention.

2. ***"ANNIVERSARY DATE"***
   The date set each year by the Plan and the employer group when the group contract is renewed.

3. ***"AUTHORIZED in ADVANCE by the PLAN"***
   Means the Member is solely responsible for ensuring that appropriate prior authorization has been obtained, in writing, by the Member from the Plan prior to obtaining Medically Necessary care or services for certain covered services as indicated herein. ***Any care or service to be provided by a provider who is not a Participating Provider must be Authorized in Advance by the Plan, except in an Emergency.*** The following types of care and services must also be Authorized ***in Advance*** by the Plan, except in an Emergency: 1) care or services to be provided by a provider who is not a Participating Provider; 2) Tertiary Care; 3) any specific type of care or service where it is indicated in this Contract that it must be Authorized ***in Advance*** by the Plan; or 4) a Participating Provider, as listed in the most recent Plan provider directory, who has a notation or designation that their services must be Authorized ***in Advance*** by the Plan.

4. ***"PRE-SERVICE CLAIM":***
   A request that benefits be provided or paid under this Contract
   The benefits requested may be in the form of:
   (a) Services (including supplies) not yet received.
   (b) Payment for all or a portion of expenses not yet incurred.
   (c) A combination of (a) and (b) above.
   (d) An indemnification not yet incurred.

5. ***"POST-SERVICE CLAIM":***
   A request that benefits be provided or paid.under this Contract
   The benefits requested may be in the form of:
   (a) Services (including supplies) received
   (b) Payment for all or a portion of expenses incurred.
   (c) A combination of (a) and (b) above.
   (d) An indemnification.

6. ***"CLAIM DETERMINATION PERIOD":***
   One year from the date the service was provided.

7. ***"COINSURANCE"***
The percentage of an eligible expense that must be paid by the Subscriber or eligible dependents.

8. ***"CONTRACT"***
This Agreement, any Supplemental Benefit Riders, the Premium Schedule and the application signed by the Subscriber.

9. ***"COST SHARING"***
The portion of benefits for which the member is responsible such as any Copayment, Deductible or Coinsurance.

10. ***"COPAYMENT"***
A specified amount a Member must pay at the time services are rendered for certain covered services.
Total copayments paid by the Subscriber and any eligible Dependents in any contract year shall not exceed two hundred percent (200%) of total annual premiums billed to the employer for that Coverage. The Subscriber should maintain a record of the copayments paid during a contract year. The Subscriber should contact the Plan within six (6) months after reaching the maximum copayment amount, to have any further copayments waived and, if necessary, to receive a refund of any excess copayments.

11. ***"DEDUCTIBLE"***
The amount each contract year that a member must pay before the Plan will be financially liable for services. A member must accumulate the deductible for services provided during the contract year.

12. "***DURABLE MEDICAL EQUIPMENT (DME)"***
Durable Medical Equipment is equipment that is primarily and customarily used for medical purposes, which is intended for repeated use and which is not useful to a person in the absence of illness or injury.

13. ***"EFFECTIVE DATE"***
The effective date of this Agreement is the date on which Members become eligible to receive benefits and services under, and pursuant to, the Contract.

14. ***"EMERGENCY"***
An emergency is any situation in which a Member, as a prudent layperson, feels sudden or immediate danger to life or limb. Medical Emergencies are acute conditions that, in the sole judgment of the Plan, meet all of the following criteria:
(a) The condition must be a Medical Emergency requiring necessary medical services for accidental injury or emergency illness.
(b) Severe symptoms must occur suddenly and unexpectedly. The symptoms must be sufficiently severe to cause a person to seek immediate medical assistance regardless of the hour of the day or night. A chronic condition

in which symptoms have existed over a period of time does not qualify for Medical Emergency consideration.

(c) Immediate care must be secured. A Medical Emergency will not be considered to exist if medical care is not secured within twenty-four (24) hours of onset. A telephone call to a doctor does not fulfill this requirement if examination and treatment by the physician is deferred until the next day. As a general rule, the date of the onset of symptoms and the date of treatment as reported on documentation received from the provider of medical services should be within twenty-four (24) hours.

(d) The illness or condition as finally diagnosed or as indicated by its symptoms was one that would require immediate medical care.

15. ***"ENROLLMENT PERIOD"***

The period of time within a Group's contract year when eligible persons, not enrolled when newly eligible, may be enrolled by submitting an enrollment form to the Plan.

16. ***"GROUP"***

The legal entity which has contracted with the Plan on behalf of its employees or members for the benefits described in this Contract.

17. ***"HOSPITAL"***

A state licensed acute care facility, which meets all of the following criteria:

(a) Is a provider of service under Medicare or is accredited as a hospital by the Joint Commission on the Accreditation of Health Organizations.

(b) Has a contract with the Plan to provide hospital services to members.

(c) Provides continuous inpatient medical, surgical, or psychiatric diagnosis, treatment and care for injured or sick persons.

A hospital is not, other than incidentally, a nursing or rest home or a place of the aged or for the treatment of substance abuse or pulmonary tuberculosis.

18. ***"INPATIENT"***

A covered person who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

19. ***"MAXIMUM OUT- OF- POCKET EXPENSE LIMIT"***

The total Eligible Medical Expenses that a member will have to incur for services in a contract year before the Plan will pay 100% of the Eligible Medical Expenses for covered services. Eligible Medical Expenses incurred for the following services do not count toward the Out-of-Pocket Expense Limit:

(a) Copayments

(b) Coinsurance for Durable Medical Equipment (DME), surgical treatment for morbid obesity, or prescription medication.

(c) Financial penalties imposed on the member for failure to comply with the requirements of the Plan's Utilization Management Program

(d) Expenses incurred in excess of a contract year maximum benefit limit or applicable lifetime benefit limit

(e) Expenses that are not Eligible Medical Expenses.

The Out-of-Pocket Expense Limit is set forth and subject to the terms of the Summary of Benefits.

20. ***"MEDICAL SUPPLIES"***

Items, which are disposable and intended for one time use.

21. ***"MEDICALLY NECESSARY"***

The use of services or supplies as provided by a practitioner or provider required to identify or treat a member's illness or injury and which, in the sole determination of the Plan, are:

(a) Consistent with the symptoms or diagnosis and treatment of the Member's condition, disease, ailment or injury.

(b) Appropriate with regard to current standards of good medical practice and consistent with guidelines of national medical, research and health care organizations and government agencies.

(c) Not solely for the convenience of the Member's Participating Practitioner, Hospital or other health care provider.

(d) The most appropriate supply or level of service that can be safely provided to the Member. Whenever specifically applied to an inpatient, it further means that the Member's medical symptoms or condition requires that the diagnosis or treatment cannot be safely provided to the Member as an outpatient.

22. ***"MEDICARE ACT"***

Title XVIII of the Social Security Act and any applicable amendments.

23. ***"MEMBER"***

Any person who meets eligibility requirements of this Contract.

(a) ***"SUBSCRIBER"***

Any person who meets the eligibility requirements of the employer group.

(b) ***"DEPENDENT"***

A person who meets the definition of a dependent of the Subscriber under the provisions of the Internal Revenue Code of the United States except as otherwise provided in Section II of this Agreement.

24. ***"OUTPATIENT"***

A covered person who receives services or supplies while not an inpatient.

25. ***"PARTICIPATING PRACTITIONER"***

Means a Physician or licensed health care professional who is affiliated with the Plan, whether individually or through a Physician group or association and who is listed in the Arnett HMO Provider Directory. Specialty services provided by a Participating Practitioner requires a referral from a Primary Care Physician and may need to be Authorized ***in Advance*** by the Plan.

A Participating Practitioner's agreement with the plan may terminate, and the Member may be required to select or be assigned to another Participating

Practitioner.
In order to be covered by the Plan, services must be rendered by a Participating Practitioner who is not a relative or family member of the Member.

26. ***"PARTICIPATING PROVIDER"***
Means a licensed Hospital, facility, a Participating Practitioner or group of Physicians or other health care professionals who are affiliated with the Plan through a contract and are authorized to furnish health services within the scope of provider's license and the Plan's health care guidelines.

27. ***"PHYSICIAN"***
Any Doctor of Medicine or Doctor of Osteopathy, who is licensed and legally entitled to practice medicine, perform surgery and dispense drugs.

28. ***"PLAN"***
Arnett HMO.

29. ***"PREMIUM"***
The periodic charges due which the covered person or the covered person's group must pay to maintain coverage.

30. ***"PREVENTIVE SERVICES"***
Services which are provided to monitor or promote wellness and not intended to diagnose or evaluate a suspected illness or injury including but not limited to; Mammography, Pap smear, Thyroid function exam, PSA blood test, Cholesterol screening, Childhood immunizations and Influenza vaccination.

31. ***"PRIMARY CARE PHYSICIAN"***
A Participating Practitioner who is a practitioner specializing in family practice, general practice, internal medicine, pediatrics or obstetrics and gynecology who provides the following services to a Member:
(a) Supervises, coordinates and provides initial care and basic medical services.
(b) Initiates referrals for specialty services to be reviewed by the Plan.
(c) Is responsible for maintaining continuity of patient care.

32. ***"SERVICE AREA"***
The geographic area in which the Plan is authorized to operate.

33. ***"TERTIARY CARE"***
A Hospital, Physician and/or other licensed health care professional contractually affiliated with the Plan to provide services that are not available within the Service Area from local Participating Providers who are listed in the Plan provider directory.
All Tertiary Care services must be referred by a Participating Practitioner and Authorized ***in Advance*** by the Plan in order to be eligible as covered benefits and services.

34. ***"URGENT CARE"***

Medical care which is appropriate to the treatment of an illness or injury that requires prompt medical attention but that is not a life-threatening emergency as defined under Emergency.

SECTION II. GROUP ELIGIBILITY AND ENROLLMENT

A. **Eligibility**

1. All active full-time (37 ½ hours per week) employees and their eligible "dependents".

2. All appointed or elected officials and their eligible "dependents".

3. Employees eligible under the Short and Long Term Disability Program remain eligible during the period of disability.

4. "Dependent" means:

   (a) Spouse of an employee.

   (b) Any unmarried dependent children, step-children, foster children, legally adopted children of the employee or spouse, or children who reside in the employee's home for whom the employee or spouse has been appointed legal guardian, under the age of 19 (or 23 if the child is a full-time student at an educational institution). Such child shall remain a "dependent" until marriage or the end of the calendar year in which he/she attains age 19/23. In the event a child who is a "dependent " as defined herein, is incapable of self-sustaining employment by reason of mental or physical disability and is chiefly dependent upon the employee for support and maintenance prior to age 19, such child's coverage will continue if satisfactory evidence of such disability and dependency is received within 120 days after the end of the calendar year in which the maximum age is attained. Coverage for the "dependent" will continue until the employee discontinues his coverage or the disability no longer exists.

   (c) Newborn children of the Subscriber or Subscriber's spouse as defined in subsection 4.b are covered as a Dependent for thirty-one (31) days following birth. An enrollment form must be submitted for continued coverage. A grandchild of Employee or Employee's spouse shall not be eligible for enrollment under this Contract, unless legally adopted by the Employee or Employee's spouse, or who reside in the Employee's home for whom the Employee or Spouse has been appointed legal guardian.

5. A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Legislator" who meets the following:

   (a) Is no longer a member of the General Assembly;

(b) Is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.;
(c) Who served as a legislator for at least 10 years.

A retired legislator who is eligible for insurance coverage under this section may elect to have the legislator's spouse covered under the health insurance program. In addition, the surviving spouse of a legislator who has died may elect to participate in the group health insurance program if all of the following apply:

(i) The deceased legislator would have been eligible to participate in the group health insurance program under this section had the legislator retired on the date of the legislator's death;
(ii) The surviving spouse files a written request for insurance coverage with the employer;
(iii) The surviving spouse pays an amount equal to the employer's and employee's premium for the group health coverage for an active employee.

The eligibility of the retired legislator's spouse, or a surviving spouse of a legislator for group health coverage is not affected by the death of the retired legislator and is not affected by the retired legislator's eligibility for Medicare. The spouse's eligibility end on the earliest of the following:

(a) When the employer terminates the health coverage program;
(b) The date of the spouse's remarriage;
(c) When the spouse becomes eligible for Medicare.

6. "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

(a) Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
(b) Must have completed twenty (20) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement;
(c) Must have fifteen (15) years of participation in a retirement fund.

7. A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Judge" who meets the following:

(a) Retirement date is after June 30, 1990;
(b) Will have reached the age of sixty-two (62) on or before retirement date;

(c) Is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.;
(d) Who has at least eight (8) years of service credit as a participant in the judge's retirement fund, with at least eight (8) years of that service credit completed immediately preceding the judge's retirement.

8. A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Prosecuting Attorney" who meet the following:

(a) Who is a retired participant under the prosecuting attorney's retirement fund;
(b) Whose retirement date is after January 1, 1990;
(c) Who is at least sixty-two (62) years of age;
(d) Who is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and
(e) Who has at least ten (10) years of service credit as a participant in the prosecuting attorney's retirement fund, with at least ten (10) years of service credit completed immediately preceding the participant's retirement.

9. Retirees eligible under subsections 6, 7 or 8 must file a written request for the coverage within ninety (90) days after retirement. At that time the retiree may elect to have the retiree's spouse covered. The spouse's subsequent eligibility to continue insurance under the surviving spouse's eligibility ends on the earliest of the following:

(a) Twenty-four (24) months from the date the deceased Retirees coverage is terminated. At the end of the period the spouse would be eligible to remain covered until the end of the maximum period under COBRA;
(b) When the spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.
(c) The end of the month following remarriage; or
(d) As otherwise provided in I.C. 5-10-8-8(g).

10. Employee on a leave of absence for ninety (90) days or less and out of pay status.

11. An employee on family leave.

12. An employee on union leave.

13. Retirees eligible under IC 5-10-12.

14. Relocation of Employee/Dependent:
Relocation of an Employee or Dependent out of the Service Area will terminate coverage at the end of the month following the relocation, except when specifically stated above. In certain instances when the Employee has been transferred to employment outside the Service Area, temporarily leaving his/her Dependents still in the Service Area, coverage for the Employee will be permitted to continue. Coverage may continue for up to ninety (90) days from the date the Employee left the service area, or until the end of the month when the Dependents leave the Service Area, whichever occurs first, subject to the requirements outlined in this Contract. Coverage outside of the service area is limited to ***Emergency services only.***

B. **Enrollment:**

Employees and their eligible Dependents may become Members under this Contract by submitting to the Plan properly completed enrollment forms during the time periods and in the manner set forth in this subsection.

1. ***Initial Enrollment:***
Prior to the Effective Date, employees of the Group will have the opportunity to enroll as Subscribers on behalf of themselves and eligible Dependents, if any, during an initial enrollment period as mutually determined by both the Plan and the Group. New employees are given to the Monday following the end of the payroll period of their date of hire to enroll. Elected officials and legislators must enroll by January 31st of the year following election or re-election.

Employees of the Group who are hired subsequent to the Effective Date may become Subscribers upon application provided they meet eligibility requirements under this Contract, subject to any waiting period established by the Group.

2. ***Special Enrollment:***
The Plan shall provide a special enrollment period during which eligible, but not previously enrolled Subscribers or Dependents may enroll under this Contract. To be eligible to enroll during a special enrollment period, the following conditions must be met:
(a) The employee or Dependent was covered under a group plan or had insurance when the Plan coverage was previously offered to that person.
(b) The employee stated in writing that another source of coverage was the reason for declining enrollment in the Plan.
(c) The employee or Dependent's coverage as described in B.2.a. above, was due to the following:
    1. Exhaustion of COBRA continuation coverage.
    2. Termination of coverage under another health plan as a result of loss of eligibility for the coverage as the result of

legal separation, divorce, death, termination of employment or reduction in the number of hours of employment.

3. Termination of coverage under another health plan as the result of termination of employer contributions toward such coverage.

(d) The employee requests enrollment within thirty (30) days after the date of exhaustion of coverage, termination of coverage or termination of employer contribution as described in B.2.c above.

3. Open Enrollment:

There will be an Open Enrollment Period annually which will commence no later than thirty (30) days in advance of the Anniversary Date. During this Open Enrollment Period, any employee of the Group shall have the opportunity to apply to become a Subscriber, subject to all applicable eligibility requirements under this Contract.

4. Late Enrollment:

An individual who does not meet the eligibility requirements outlined in this Section and who does not enroll in accordance with subsection 1 and/or subsection 2 will not be eligible for enrollment until the following Open Enrollment Period, unless permitted due to a qualifying event under Section 125 of the Internal Revenue Code.

SECTION III. BENEFITS AND SERVICES

A. **Plan Authority:**

The Plan shall have sole authority to make all determinations that are required for the administration of this Contract including determinations regarding medical necessity and covered benefits, to make factual findings, and to construe and interpret this Agreement whenever necessary to carry out its intent and purpose and to facilitate its administration. This provision applies only where the interpretation of this Agreement is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 *et seq*. All such determinations, constructions, and interpretations made by the Plan, and in accordance with applicable law, shall be binding upon the Member.

The benefits and services which the Plan agrees to provide to, or make arrangements for Members, and the exclusions and limitations applicable to those benefits and services, are those set forth in Sections III and IV**.** Members must select a Primary Care Physician from those Participating Practitioners within the areas of General Practice, Family Practice, Internal Medicine, Pediatrics, or Obstetrics and Gynecology. ***For all purposes under this Contract, except as specifically excluded by the Plan, these benefits and services are available only if, and to the extent that, they are Medically Necessary (except where otherwise specifically provided). Further, for care and services to be eligible as covered benefits under this Contract they must be provided by the Member's Primary Care Physician or ordered, prescribed or directed by the Member's Participating Primary Care Physician and provided by a Participating Provider.***

Specialty care and consultations within the Service Area should be coordinated and directed by the Member's Primary Care Physician and provided by a Participating Practitioner. Some specialty services within the Service Area may need to be Authorized ***in Advance*** by the Plan. And specialty care and consultations, including Tertiary Care, by a provider outside the Service Area must always be Authorized ***in Advance*** by the Plan and should be coordinated and directed by the Member's Primary Care Physician, except in an Emergency. The Plan reserves the right to further define a "practitioner" and "physician".

Approval for a requested service which is required to be Authorized ***in Advance*** by the Plan must be submitted to the Plan in writing via facsimile or postal service by the Member's Primary Care Physician, or other treating Participating Provider as appropriate, the request will be evaluated by the Plan and a response communicated in writing to the Member and the requesting Physician. Therefore, ordinarily the Member will not be required to take any personal action in order to obtain the required advance authorization. However, for requested services that are required to be Authorized in Advance, it is ultimately the Member's responsibility to confirm that such authorization has been obtained before proceeding with the services. A Member needing services that are required to be Authorized ***in Advance*** by the Plan which have not been approved in advance by

the Plan will be the sole financial responsibility of the Member. If advance approval has been properly sought and the Plan denies the requested service, the Member should receive a communication from the Plan informing the Member of the denial. However, a Member may contact the Member Services Department at 800/448-7440 or 765/448-7440 Monday through Thursday 8:00 am to 6:00 pm or Friday 8:00 am to 5:00 pm or log onto the Plan's web site at www.arnettplans.com to confirm that the requested service has been Authorized ***in Advance*** by the Plan or denied by the Plan.

Hospital inpatient services, except in an emergency, must be obtained at a Hospital that is a Participating Provider. Under special circumstances and based upon medical need, the Plan may authorize services at a hospital that is not a Participating Provider.

The Plan reserves the right to modify the list of Participating Practitioners at any time, and Members may need to select another Participating Practitioner in order to receive covered benefits.

The Member is solely responsible for ensuring that appropriate prior authorization has been obtained, in writing, by the Member from the Plan prior to obtaining Medically Necessary care or services for certain covered services as indicated herein. ***Any care or service to be provided by a provider who is not a Participating Provider must be Authorized in Advance by the Plan, except in an Emergency.*** The following types of care and services must also be Authorized ***in Advance*** by the Plan, except in an Emergency: 1) care or services to be provided by a provider who is not a Participating Provider; 2) Tertiary Care; 3) any specific type of care or service where it is indicated in this Contract that it must be Authorized ***in Advance*** by the Plan; or 4) a Participating Provider, as listed in the most recent Plan provider directory, who has a notation or designation that their services must be Authorized ***in Advance*** by the Plan.

All benefits are subject to further clarification through the Plan's Benefit Interpretation Process.

B. **Filing a Claim:**

Participating Providers and Practitioners bill the Plan directly, you should not have any Claims (bills) to submit to the Plan. The exception may be if you receive care from an ambulance Practitioner or Non-Participating Provider or Practitioner. In that case, follow the steps described in this Section.

Step 1:

To assist in processing Claims as quickly as possible, be sure to include all information requested.

- Your Member identification number
- The itemized bill showing:

- Date treatment was received;
- Description of service;
- Itemized charges;
- Diagnosis code and;
- The Provider or Practitioner's name, address, phone number and federal tax ID number.

- If you or your dependent has coverage under more than one plan, be sure to include the name of the other plan.
- If you or your dependent has coverage under more than one plan, and this Plan is secondary, you should file with the plan (the primary plan) before you submit your claim. After the Claim has been paid by the primary plan, send a copy of that explanation of benefit with any Claims you submit to the Plan.

Step 2:

Most Participating Providers and Practitioners will file Claims for you. When you or your dependent must file a Claim, mail them to the Plan at:

Arnett Health Plans
PO Box 6108
Lafayette, In 47903-6108

Or drop off your Claim between the hours of 8:00 am and 5:00 pm, Monday through Friday at:

Arnett Health Plans
415 North 26TH Street
Lafayette, IN 47903
765/448-7440 or 888/448-7440

Be sure to keep copies of all forms, bills, and receipts for your own records.

C. **Inpatient Services:**

These benefits and services are available only if, and to the extent that, they are Medically Necessary (except where otherwise specifically provided). Further, for care and services to be eligible as covered benefits under this Contract they must be provided by the Member's Primary Care Physician or ordered, prescribed or directed by the Member's Participating Primary Care Physician and provided by a Participating Provider.

1. ***Inpatient Hospital:***
When ordered by a Participating Practitioner and Authorized ***in Advance*** by the Plan, the following inpatient hospital services are provided: Semi-private room and board, nursing care, use of operating room, anesthesia, administration of whole blood or plasma, intensive care facilities, diagnostic and therapeutic radiology, laboratory procedures, medications,

and all related Medically Necessary supplies and services.

2. ***Transplants:***
Lung, heart, heart-lung, cornea, cochlear implants, kidney, pancreas, adult liver, liver for children with biliary atresia and other rare congenital abnormalities, bone marrow transplants for aplastic anemia and leukemia, and allogeneic bone marrow transplants for severe combined immunodeficiency disease and Wiscott-Aldrich syndrome, will be covered when such transplants are Medically Necessary, medically appropriate for the medical condition for which the transplant is proposed, rendered in a transplant facility as designated and directed by the Plan, and prior Authorized ***in Advance*** by the Plan.

If a Member is denied a transplant procedure by the designated transplant facility, the covered person shall be referred by the Plan to a second facility for evaluation. If the second facility determines, for any reason, that the covered person is an unacceptable candidate for the transplant procedure, no coverage will be provided for further transplant related services and supplies regardless of any other transplant facilities acceptance of the covered person.

3. ***Skilled Nursing Facility:***
Skilled nursing care is covered when determined by the Plan to be Medically Necessary and received in a state licensed skilled nursing facility. Custodial, basic or residential care is not covered. Limits may apply for these services; refer to the Summary of Benefits insert.

4. ***Inpatient Rehabilitation:***
Inpatient rehabilitative services are covered when determined by the Plan to be Medically Necessary. Short-term rehabilitative services are limited to sixty (60) daysof outpatient and/or inpatient treatment per benefit year when ordered by a Participating Practitioner and only if significant improvement can be expected within the sixty (60) days. See Section III.E for further description of this benefit.

5. ***Hospice Care:***
Hospice care for non-curative medical and support services are provided in the case of a terminal illness as diagnosed by a Participating Practitioner and according to Plan guidelines. Hospice services must be Authorized ***in Advance*** by the Plan for each level of care to ensure appropriateness with Plan guidelines.

D. **Outpatient Services:**
These benefits and services are available only if, and to the extent that, they are Medically Necessary (except where otherwise specifically provided). Further, for care and services to be eligible as covered benefits under this Contract they must be provided by the Member's Primary Care Physician or ordered,

prescribed or directed by the Member's Participating Primary Care Physician and provided by a Participating Provider.

1. ***Physician Services:***
   Preventive and routine professional services for diagnosis, treatment, therapy, surgery, and consultation are covered.

2. ***Outpatient Hospital:***
   When ordered by a Participating Practitioner the following outpatient hospital services are provided: ambulatory surgery, which must be Authorized ***in Advance*** by the Plan, and other outpatient diagnostic procedures and testing.

3. ***Preventive Services:***
   (a) Routine Well Care:
   Routine well care and examinations and related laboratory tests and x-rays (services which are not intended to diagnose or evaluate suspected illness or injury) are provided when performed or ordered by the Member's Primary Care Physician according to the Plan's guidelines.
   (b) Well Child Care:
   Well child examinations, developmental assessments and anticipatory guidance necessary to monitor the normal growth and development of a child when performed by the Primary Care Physician.
   (c) Immunizations:
   Pediatric and adult immunizations, in accordance with the Plan's guidelines and accepted medical practice, except those specifically excluded in Section IV.

4. ***Maternity and Newborn Care:***
   (a) In plan physician and hospital services, including prenatal, delivery and postnatal care are provided while the mother is enrolled in the Plan regardless of when conception occurs.
   (b) Care of the newborn, including illness, injury, congenital anomalies and premature birth are covered.
   (c) Services provided by a Participating Practitioner for spontaneous miscarriage of pregnancy are provided at any time during the pregnancy.
   (d) Termination of pregnancy by any means is provided only when the life of the mother would be endangered if the fetus were carried to term or if the pregnancy is a result of rape, incest, and only when Authorized ***in Advance*** by the Plan.
   (e) In accordance with the Summary of Benefits, Cost Sharing may be applicable for each covered maternity care inpatient Hospital admission.
   (f) In accordance with the Summary of Benefits, a single office visit

Copayment may be applicable at the initial prenatal appointment only.

(g) Upon admission to the hospital for delivery, Member Cost Sharing will apply to the mother's charges (see Summary of Benefits insert). If the newborn is admitted for services beyond standard nursery care, additional Member Cost Sharing may be applicable for the baby's charges (see Summary of Benefits insert).

5. ***Family Planning:***

Family planning counseling services (including pregnancy testing) and reproductive health information only when provided by or coordinated by the Member's Primary Care Physician.

6. ***Artificial Insemination:***

Artificial insemination, when related to infertility and provided by a Participating Practitioner is covered. Donor sperm and charges related to sperm preparation are not covered. Artificial insemination is limited to three (3) unsuccessful attempts. All infertility services must be Authorized ***in Advance*** by the Plan. Infertility services are limited to diagnostic procedures and counseling to include surgical, laboratory and X-ray services that are used to diagnose the condition of infertility.

7. ***Reconstructive Surgery:***

(a) With special exception of breast reconstruction criteria listed below, reconstructive and/or plastic surgery procedures are covered when performed to correct a congenital anomaly or when performed to correct a condition resulting from accidental injury or trauma, or surgical trauma that occurred while the Member was covered by the Plan and has resulted in a functional deficit. Procedures must be performed within two (2) years of injury or surgical trauma except in cases involving children who may require a growth period, and must be Authorized ***in Advance*** by the Plan.

(b) The Plan will cover breast reconstruction incident to a mastectomy, including reconstruction of the other breast to provide symmetry . Coverage for prosthesis and any physical complications resulting from or incident to the mastectomy, including lymphedema, will also be provided.

8. ***Oral Surgery:***

Oral surgery and x-rays are a benefit only when ordered by a Participating Practitioner and Authorized ***in Advance*** by the Plan for:

(a) Treatment of fractures of the jaw and facial bones, and dislocation of the jaw.

(b) Oral surgery necessary for repair and pain management of accidental trauma of the jaw, natural teeth, cheeks, lips, tongue, and roof and floor of the mouth when initiated within 48 hours of

incident and concluded within one (1) year of the original incident. Restorative work, such as crowns and dentures or any services related to orthodontia needed as a result of an accidental trauma is not a covered benefit.

(c) Medically Necessary surgical procedures for treatment of lesions, tumors and cysts on or in the mouth.

9. ***Eye Examinations:***

Annual examinations to determine the need for vision correction are covered for Members through age seventeen (17). Services for treatment of eye diseases and injury are covered under Physicians Services.

10. ***Hearing Tests:***

Hearing tests and audiograms are covered only when performed in connection with a disease, illness or injury.

11. ***Urgent and Emergency Medical Care:***

Benefits are provided for urgent and emergency medical services whether rendered inside or outside of the Plan's Service Area.

(a) Urgent Care: Medical direction and advice is available through the Member's Primary Care Physician, seven (7) days a week, twenty-four (24) hours a day. All urgent care services whether inside or outside of the Service Area should be directed by the Member's Primary Care Physician. Urgent care services provided by a facility that is not a Participating Provider may only be used if the Member cannot reasonably access a Participating Provider facility.

(b) Emergency Care: Benefits are not provided for the use of an emergency room except for emergency care. In the event of an Emergency, the Member should go to a Participating Practitioner unless the Member's condition requires him/her to go to the nearest Emergency Room. Medical services shall be covered less any applicable Copayment for medical services when the Member, as a prudent layperson, feels the condition meets the following criteria:

1. The life or health of the Member would be in immediate danger if the rendering of such care were delayed until such care could be obtained through the Member's Primary Care Physician;
2. The Member, if an adult, is in shock or has been unconscious so as to be incapable of rational independent judgment concerning the medical treatment or services rendered; or
3. The Member, if a minor, has been alone or without the presence of an adult of his/her family or his/her legal guardian from the onset of the Emergency.

12. ***Treatment of Morbid Obesity***
The surgical treatment of Morbid Obesity may be a covered benefit under this Contract if the Group has purchased the Treatment of Morbid Obesity rider (see Summary of Benefits insert)

13. ***Pervasive Developmental Disorder***
When ordered by a Participating Practitioner, in accordance with a treatment plan that shall be shared with the Plan, benefits are provided for the treatment of Pervasive Developmental Disorder (PDD) a neurological condition, including but not limited to Asperger's syndrome and autism. No other service exclusions in conflict with this provision applies. Deductibles, copays, and coinsurance may apply for these services as they generally apply to any physical illness under this Contract; refer to the Summary of Benefits insert.

E. **Ancillary Services:**
These benefits and services are available only if, and to the extent that, they are Medically Necessary (except where otherwise specifically provided). Further, for care and services to be eligible as covered benefits under this Contract they must be provided by the Member's Primary Care Physician or ordered, prescribed or directed by the Member's Participating Primary Care Physician and provided by a Participating Provider.

1. ***Laboratory, Radiology and Diagnostic Services:***
All radiology and laboratory tests and services received in an inpatient or outpatient setting, including, but not limited to, diagnostic radiology, radiation therapy, electrocardiograph (EKG), electroencephalograms (EEG), allergy tests and ultrasonography (ultrasound).

2. ***Injectables:***
(a) Chemotherapy, radioactive materials used for therapeutic purposes, allergy testing and allergy treatment materials.
(b) Medically Necessary prescribed injectables, administered in a Physician's office or as a part of a prescription drug benefit.

3. ***Durable Medical Equipment (DME):***
All Durable Medical Equipment must meet the Plan's guidelines in order to be considered for coverage. DME is equipment that is primarily and customarily used for medical purposes, which is intended for repeated use and which is not useful to a person in the absence of illness or injury. DME may be rented or purchased and is limited to the basic equipment plus medically necessary special features and obtained from an approved supplier. Limits may apply for these services; refer to the Summary of Benefits.
Coverage of duplication of DME items for any reason is excluded.

4. ***Supplies:***
Supplies determined by the Plan, to be ***Medically Necessary*** to ensure proper function for an approved DME may be covered. Covered items include but are not limited to; C-Pap masks, ostomy pouches, surgical stockings and feeding tubes. Member Cost Sharing responsibility is listed under the "other physician services" section of the Summary of Benefits insert.

5. ***Prosthetic Devices:***
Prosthetic devices that are used to replace a body part or perform a body function are covered unless specifically excluded in Section IV, when Authorized ***in Advance*** by the Plan and obtained from an approved supplier.

Fitting, repair and replacement of fitted devices are covered when necessary to make the equipment functional when Authorized ***in Advance*** by the Plan and obtained from an approved supplier. Breast Prosthetics may be replaced every 2 years and up to 2 brassieres annually.
Limits may apply for these services; refer to the Summary of Benefits.

Routine maintenance, repair or replacement due to intentional abuse or misuse of items or supplies is not covered.

6. ***Home Health Services:***
Skilled home healthcare, supplies and injectables, when Medically Necessary and when Authorized ***in Advance*** by the Plan that are provided by a state licensed home health agency to a home bound patient are covered. Home care does not include home health aids or housekeeping services and is not a benefit for the purpose of providing long term custodial maintenance.

7. ***Ambulance Service:***
Emergency ambulance services are provided in the case of accidental injury or medical emergency to the nearest facility where emergency care can be rendered; or for Medically Necessary transfer between facilities.

8. ***Alcoholism, Drug Abuse and Addiction Services:***
Detoxification, diagnosis and medical treatment for the abuse of, or addiction to alcohol and drugs are covered on either an inpatient or outpatient basis, whichever is determined to be Medically Necessary, and when Authorized ***in Advance*** by the Plan, and provided by a Participating Provider, except in an Emergency. Limits may apply for these services; refer to the Summary of Benefits.
Non-medical ancillary services such as vocational rehabilitation, long-term counseling and prolonged rehabilitation services in a specialized inpatient or residential facility are not covered.

9. *Mental Health Services*

Mental Health Services provided for crisis intervention, diagnosis and treatment of acute mental or nervous conditions or an acute phase of a chronic condition are covered only if, and to the extent, that they are Medically Necessary and Authorized ***in Advance*** by the Plan, except in an Emergency. Conditions may apply for these services; refer to the Summary of Benefits.

Inpatient and outpatient mental health services must be provided or directed by a Participating Provider who is a psychiatrist, registered clinical psychologist, or psychiatric social worker.

F. **Therapy Services:**

These benefits and services are available only if, and to the extent that, they are Medically Necessary (except where otherwise specifically provided). Further, for care and services to be eligible as covered benefits under this Contract they must be provided by the Member's Primary Care Physician or ordered, prescribed or directed by the Member's Participating Primary Care Physician and provided by a Participating Provider.

Short-term therapy services are limited to sixty (60) days per benefit year of inpatient and/or outpatient treatment when ordered by a Participating Practitioner and only if significant improvement can be expected within the sixty (60) days. The treatment of an acute condition, by any means, will be presumed to become maintenance care and not a covered service after sixty (60) days of treatment. Therapy services include:

1. Physical and/ or Occupational Therapy Services:

(a) Physical Therapy*:*

The treatment by physical methods such as, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neurophysiological principles, and devices to relieve pain, restore maximum function and prevent disability following disease, injury, or loss of a body part.

(b) Occupational Therapy:

The treatment program of prescribed activities, emphasizing coordination and mastery, designed to assist a person in the normal activities of daily living following disease, injury or loss of a body part.

2. Speech Therapy:

The treatment to restore speech loss due to illness or accidental injury.

F. **Rehabilitative Services:**

These benefits and services are available only if, and to the extent that, they are Medically Necessary (except where otherwise specifically provided). Further, for care and services to be eligible as covered benefits under this Contract they must be provided by the Member's Primary Care Physician or ordered, prescribed or directed by the Member's Participating Primary Care Physician and provided by a Participating Provider.

Short-term rehabilitative servicesare limited to sixty (60) days per benefit year of inpatient and/or outpatient treatment when ordered by a Participating Practitioner and only if significant improvement can be expected within the sixty (60) days. The treatment of an acute condition, by any means, will be presumed to become maintenance care and not a covered service after sixty (60) days of treatment. Rehabilitation services include:

Cardiac/Pulmonary Rehabilitation:

Limited to 60 days of combined therapy per benefit year.

(a) Cardiac Rehabilitation:

Phase I and II (telemetry monitoring) is covered for Members who have suffered a cardiac event during the 12 month period prior to receiving cardiac rehabilitation when ordered by a Participating Practitioner. Cardiac Rehabilitation for phase III , IV and non supervised exercise is not a covered benefit.

(b) Pulmonary Rehabilitation:

Phase I and II (telemetry monitoring)is covered for Members when ordered by a Participating Practitioner. Pulmonary Rehabilitation for phase III , IV and non supervised exercise is not a covered benefit.

SECTION IV. EXCLUSIONS

A. **General Exclusions:**

1. Health, medical, hospital, drugs and other services obtained by a Member which are:
    1) obtained from a provider who is not a Participating Provider; or
    2) ordered by a practitioner who is not a Participating Practitioner; or
    3) not Authorized ***in Advance*** by the Plan when ordered by a Participating Practitioner and provided by a provider who is not a Participating Provider

   are not covered benefits and will not be reimbursed to the Member or paid for by the Plan. This exclusion does not apply for an Emergency as specified in Section III of this document.
2. Any service that, in the sole judgment of the Plan, is not Medically Necessary.
3. Expenses incurred prior to membership in the Plan or services rendered after the Plan coverage or eligibility terminates, except as otherwise provided in this Agreement.
4. Services, supplies, or other care provided in treatment of injuries or illnesses sustained in or resulting from participation in a riot or civil disturbance or while committing or attempting to commit an assault or felony.
5. Services, supplies, or other care required while incarcerated in a federal, state or local penal institution or requiring transport from a federal, state or local penal institution or a work release program.
6. Services that are provided to you if the care is furnished to you without charge or would normally be furnished to you without charge. This exclusion also applies to care that would have been provided without charge if you were not covered under this contract or under any other insurance.
7. Care for military service connected disabilities for which the Member is legally entitled and for which facilities are reasonably available.
8. Genetic testing for any reason.
8. Any type of services, supplies or treatments not specifically provided herein.
9. Inpatient, emergency room and outpatient treatment of complications related to or as a result of non-covered services. Examples of exclusion include but are not limited to, complications related to cosmetic services, LASIK, infertility treatment, dental care, and/or alternative/complimentary medicine treatments or any revision of previous non-covered or excluded surgeries.
10. Any Claim submitted by a member, non contracted provider or non contracted practitioner for payment after the Claim Determination Period has lapsed.
11. All exclusions are subject to further clarification through the Plan's Benefit Interpretation Process.

B. **Inpatient Exclusions:**

1. Coverage of hospitalizations when Subscriber and/or dependent(s) leave an inpatient setting against medical advice.
2. Private hospital room.
3. Private duty nursing at home or during hospitalization.
4. Custodial or residential care.
5. Organ donor treatment or services where the Member serves as the organ donor for a non-Member recipient.
6. Home birth services.

C. **Surgical Exclusions:**

1. Any services in connection with elective cosmetic surgery which is primarily intended to improve your appearance, or which is not, in the sole judgment of the Plan, medically necessary. Psychological issues related to the intended procedure will not be considered when making benefit coverage decisions.

   Examples of exclusions include, but are not limited to, removal of tatoos, scars, wrinkles or excess skin; plastic surgery; silicone injections or implants; electrolysis; wigs including those used as cranial prosthesis; treatment of male pattern baldness; correcting breast size disproportion or asymmetry, except following mastectomy for the treatment of cancer; revision of previous elective surgeries; keloids; pharmaceutical regimes; nutritional procedures or treatments; rhinoplasty; epikeratophakia surgery; skin abrasions which are performed as a treatment for acne.
2. Treatment for obesity, including but not limited to, surgical stapling, bypass, or gastric balloon; dietary management, or any weight loss drug or program. Surgical treatment of Morbid Obesity may be a covered benefit under this Contract if the Group has purchased the Treatment of Morbid Obesity rider (see Summary of Benefits insert).
3. Radiokeratotomy or any other surgery intended to improve vision not related to disease or injury.
4. Reduction mammoplasty.

D. **Outpatient Service Exclusions:**

1. ***Physician/Outpatient Hospital:***
   (a) Examination, immunizations and/or reports for employment, licensing, insurance, travel, adoption, school or school sports physicals. However periodic routine physical exams, which require a significantly more detailed health assessment, are a covered benefit.
   (b) Expenses for medical reports, including but not limited to, physician, laboratory and radiology services and/or report preparation and presentation, used for the determination of disability or for the determination of other non-covered services.
   (c) High dose chemotherapy with autologous bone marrow transplant for the treatment of breast cancer or other conditions when

considered experimental.

(d) Any procedure, medical evaluation or psychological evaluation or treatment designed to alter physical characteristics of the Member to those of the opposite sex, and any other evaluation, treatment or studies related to sex transformations.

(e) Work hardening programs.

(f) Pain management clinics for chronic pain and/or rehabilitative services.

(g) Marriage counseling.

(h) Procedures, services and supplies in conjunction with routine foot care.

(i) Electrolysis for any condition.

(j) Home health care services that do not require skilled care, such as housekeeping, homemaker and meal services.

(k) Charges for, or in connection with, travel or transportation even when prescribed by a physician, except for ambulance transports in accordance with Section III.

(l) Charges for medical services by an Ambulance or EMT if transport is not provided.

(m) Court-ordered tests, procedures, therapies, and confinements in conjunction with, but not limited to, probation, emergency detention orders or as a condition of parole.

2. ***Family Planning:***

(a) Services related to conception by artificial means (except artificial insemination), including but not limited to, drug therapy, in-vitro fertilization, embryo transfers, G.I.F.T., Z.I.F.T., donor sperm, services related to surrogate parenting, and any other surgical or non-surgical procedure.

(b) Any treatment performed to assist in achieving conception with or without the diagnosis of infertility is not covered. This includes but is not limited to medications, ultra sounds, hormone level determinations and related laboratory tests, and laproscopies.

(c) Reversal of voluntary sterilization procedures and related procedures, services and supplies, and any procedure necessary for conception as a result of voluntary sterilization.

(d) Any medications, procedures and/or devices used to treat or aid erectile or sexual dysfunction.

E. **Dental:**

1. Dental services, including the dental-related use of drugs, anesthetics, prosthetics, examinations, consultations and hospitalization for dental-related care; restorative work, such as crowns and dentures or any services related to orthodontia.

Coverage for anesthesia and hospital charges for dental care will be

covered at a participating facility if the mental or physical condition of the member requires dental treatment to be provided in a hospital and/or the individual is less than nineteen years old. Determination for coverage for general anesthesia and facility charges will be based upon the American Academy of Pediatric Dentistry guidelines.

2. Dental treatment, care of gums or bones supporting the teeth, removal of impacted teeth, false teeth, orthognathic treatment and surgery, orthodontia, root canals or any other dental related services are not covered.
3. Any dental appliance.

F. **Rehabilitative Services:**

1. Developmental testing and treatment for psychological, behavioral, intellectual, fine and gross motor, or speech are excluded. Treatment of behavioral, developmental or learning disabilities are not covered.
2. Respiratory therapy and related items for home use except as Authorized ***in Advance*** by the Plan.
3. Therapy for chronic conditions, and any long-term rehabilitation, including but not limited to, speech therapy, cognitive therapy, physical therapy and occupational therapy.
4. Biofeedback and relaxation therapies.
5. Acupuncture for any condition.
6. Chiropractic services, including treatments and tests ordered by a chiropractor.
7. Visual therapy and orthoptic therapy.
8. Massage therapy.
9. Cardiac and Pulmonary Rehabilitative Services for phase III , IV and any non- supervised exercise.

G. **Supplies/Medical Equipment:**

1. Corrective appliances, orthotics and non-durable medical equipment and supplies (such as elastic stockings, specially made shoe inserts, and orthopedic shoes unless attached to a brace) except as provided in Section III.
2. Durable medical equipment except as provided in Section III.
3. Single patient use, self-administered dressings and other disposable supplies. Supplies determined by the Plan, to be ***Medically Necessary*** to ensure proper function of an approved DME may be covered. Covered items include but are not limited to; C-Pap masks, ostomy pouches, surgical stockings and feeding tubes. Member Cost Sharing responsibility is listed under the "other physician services" section of the Summary of Benefits insert.

4. Hearing aids
5. Routine hearing tests and audiograms not performed in connection with a disease, illness or injury.
6. The fitting and purchase of eyeglasses (including the refraction), contact

lenses, and therapeutic lens, except the first lens and/or contact to restore vision after cataract surgery, when surgery occurs while enrolled in the Plan.

7. Vision testing or refractions for member over age 17.
8. Personal comfort or convenience items used for other than medical purposes such as, but not limited to, air conditioners, humidifiers, physical fitness equipment, personal computers, television, telephone and guest meals or rooms.
9. Items that can be purchased over the counter without a prescription at a retail establishment including but not limited to ace bandages, shoe inserts, blood pressure monitors, batteries, and breast pumps.

H. **Experimental/Investigational**:

Drugs, devices, services, supplies, medical treatments or procedures which are experimental or investigational in nature. The Plan will apply the following criteria in determining whether services or supplies are experimental or investigational:

1. Any medical device, drug or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition.
2. Conclusive evidence from the published peer-review medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding efficacy and rationale.
3. Demonstrated evidence as reflected in the published peer-review medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects.
4. Proof as reflected in the published peer-reviewed literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.
5. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

SECTION V. GRIEVANCE PROCEDURES

A Member may provide the Plan with a written authorization for an authorized representative to represent and act on his or her behalf and consent to the release of information related to the Member to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Plan.

NOTICE OF BENEFIT DENIAL

Pre-Service Claims

After a completed ***pre-service claim*** has been submitted to the Plan, if a Member's claim for benefits is denied, the Plan shall provide the Member or authorized representative with a written notice of benefit denial within a reasonable period of time appropriate to the medical circumstances but not later than two (2) business days of receipt of the claim unless an extension is necessary due to circumstances beyond the Plan's control. If such circumstances exist, the Plan may one time extend this period for up to fifteen (15) calendar days and shall provide the Member or authorized representative within the original fifteen (15) day period with a notice to this effect stating the date by which the Plan expects to make a decision.

If the need for this extension is due to the fact that additional information is needed for the determination of the claim ("incomplete claim"), the Plan will in this notice of extension to the Member (or authorized representative) detail the additional information needed. The Member will have forty-five (45) calendar days to provide the information requested, and the Plan will complete its determination of the claim within fifteen (15) calendar days of the Plan's receipt of the requested information. Failure by the Member to respond in a timely and complete manner will result in the denial of benefit payment.

Post-Service Claims

After a completed ***post-service claim*** has been submitted to the Plan, if a Member's claim for benefits is denied, the Plan shall provide the Member or authorized representative with a written notice of benefit denial within a reasonable period of time but not later than thirty (30) calendar days of receipt of a claim submitted on paper or forty-five (45) calendar days for a claim submitted electronically.

Urgently Needed Care Claims

In the case of a claim involving ***urgently needed care***, the Plan will notify the Member or authorized representative of the benefit determination (whether adverse or not) as soon as possible taking into account the medical emergencies, but not later than forty-eight (48) hours after receipt of the claim, unless the Member fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. In the case of such a failure, the Plan will notify the Member or authorized representative as soon as possible, but not later than twenty-four (24) hours after receipt of the claim, of the

specific information necessary to complete the claim. The Member will have forty-eight (48) hours to provide the specified information. The Plan will notify the Member or authorized representative of the benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of (i) the receipt by the Plan of the specified information, or (ii) the end of the forty-eight (48) hour period given the Member to provide the specified additional information.

Concurrent Care Decisions

If the Plan has approved for the Member an ongoing course of treatment to be provided over a period of time or number of treatments –

(i) Any reduction or termination by the Plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments will be considered to be a benefit denial. The Plan will notify the Member or authorized representative of the benefit denial with sufficient time in advance of the reduction or termination to allow the Member to appeal and obtain a determination on review of the denial before the benefit is reduced or terminated.

(ii) Any request by the Member to extend the course of treatment beyond the period of time or number of treatments that is considered to be an ***urgently needed care claim*** will be decided as soon as possible, taking into account the medical emergencies, and the Plan will notify the Member or authorized representative of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt by the Plan of the claim, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

Notice of Benefit Claim Denial

Any required notice of benefit claim denial shall include an explanation of the denial, including:

1. The specific reasons for the denial;
2. Reference to the *Summary of Benefits* and/or Plan provisions on which the denial is based;
3. A description of any additional material or information necessary and an explanation of why such material or information is necessary;
4. A description of the Plan's claim review procedure and applicable time limits;
5. A statement that if the Member's appeal is denied, the Member has the right to bring a civil action under section 502(a) of ERISA;
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the notice of benefit denial will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request;

7. If denial was based on medical necessity, ***experimental*** treatment or similar exclusion or limit, the Member will be supplied with either:

   a. An explanation of the scientific or clinical judgment, applying the terms of the Contract to the Member's medical circumstance, or

   b. A statement that such explanation will be supplied free of charge, upon request.

APPEALING A DENIED PRE-SERVICE CLAIM

A. Initial Appeal Process

A Member (or his or her authorized representative) may request a review of a denied claim by making an oral or written request for reconsideration to the Plan within one hundred eighty (180) calendar days from receipt of notification of denial. The request for reconsideration should include the reasons the Member feels the claim should not have been denied. All written requests for reconsideration should be addressed to:

Arnett HMO, Inc.
Member Services Department
P.O. Box 6108
Lafayette, IN 47903-6108

An acknowledgement letter detailing the appeal process will be forwarded to the Member within three (3) business days of the Plan' receipt of the request for reconsideration.

Upon receipt of the request for reconsideration, the Health Services Committee will review the request. The Member will be informed in writing of the Health Services Committee's decision within fifteen (15) calendar days of receipt of the Member's request.

B. Grievance (Second Level Appeal) Process

If the Member disagrees with the decision made by the Health Services Committee, the Member may submit another oral or written request for reconsideration to the Grievance Committee. This request may be filed to the Grievance Committee at any time within sixty (60) calendar days after the Member has received the Health Services Committee's decision.

Each Member has the right to attend the Grievance Committee hearing either in person or through telephone conference. The Member will be informed in writing of the date, time and location of the hearing.

The Grievance Committee hearing will be held, a decision rendered and notification of the decision sent to the Member within fifteen (15) calendar days of receipt of the

Member's request for review.

C. Expedited Appeal for Urgently Needed Care Claims

A Member (or his or her authorized representative) may request a review of a denied urgent care claim by making an oral or written request for reconsideration to the Plan within one hundred eighty (180) calendar days from receipt of notification of denial.

An expedited appeal decision will be made as soon as possible within forty-eight (48) hours after (i) receipt of the appeal request, and (ii) all information necessary to complete the expedited appeal is received by the Health Services Committee physician, but in no event later than seventy-two (72) hours after receipt of the Member's request for an expedited appeal and the Member will be notified of the expedited appeal decision also within this time frame.

APPEALING A DENIED POST-SERVICE CLAIM

A. Initial Appeal Process

A Member (or his or her authorized representative) may request a review of a denied claim by making an oral or written request for reconsideration to the Plan within one hundred eighty (180) calendar days from receipt of notification of denial. The request for reconsideration should include the reasons the Member feels the claim should not have been denied. All written requests for reconsideration should be addressed to:

Arnett HMO, Inc.
Member Services Department
P.O. Box 6108
Lafayette, IN 47903-6108

An acknowledgement letter detailing the appeal process will be forwarded to the Member within three (3) business days of the Plan' receipt of the request for reconsideration.

Upon receipt of the request for reconsideration, the Health Services Committee will review the request. The Member will generally be informed in writing of the Health Services Committee's decision within twenty (20) business days after receipt of the Member's request for Initial Appeal. However, if the Committee is unable to make a decision within that time due to circumstances beyond its control, the Committee will notify the Member or authorized representative in writing of the reason for the delay before the twentieth business day, and issue a written decision within an additional period that cannot extend beyond thirty (30) calendar days after the Committee's receipt of the Initial Appeal request. The notification of the decision will be sent to the Member or authorized representative by the earlier of within five (5) business days after the decision or not later than thirty (30) calendar days of the Committee's receipt of the Initial Appeal request.

B. Grievance (Second Level Appeal) Process

If the Member disagrees with the decision made by the Health Services Committee, the Member may submit another oral or written request for reconsideration to the Grievance Committee. This request may be filed to the Grievance Committee at any time within sixty (60) calendar days after the Member has received the Health Services Committee's decision.

Each Member has the right to attend the Grievance Committee hearing either in person or through telephone conference. The Member will be informed in writing of the date, time and location of the hearing.

The Grievance Committee hearing will be held, a decision rendered, and notification of the decision sent to the Member within thirty (30) calendar days of receipt of the Member's request for review.

C. External Review Process

If the member is dissatisfied with the decision made by the Grievance Committee, the member may request review by an external independent review organization approved by the State of Indiana by submitting a written request and any additional data to the Member Services Department. This organization may resolve grievances regarding;

- an adverse utilization review determination: or
- an adverse determination of medical necessity: or
- a determination that a proposed service is experimental or investigational

The organization may also review your case to decide whether one of the three qualifications might apply.

This request ***must*** be received within forty-five (45) days after the member is notified of the Grievance Committee's decision.

- The member will be required to pay a fee of twenty-five dollars ($25) toward the cost of the external review.

An independent review organization (IRO) will be selected to review the case from a list of independent review organizations certified by the Indiana Department of Insurance.
The plan will select a different IRO for each appeal, rotating the choice of an IRO among all certified independent review organizations before repeating a selection.
The independent review organization will review all data submitted and render a decision within seventy-two (72) hours for an expedited appeal and within fifteen (15) days for a standard appeal of receiving the review request.
Arnett HMO and the member will be notified in writing within twenty-four (24) hours for an expedited appeal and seventy-two (72) hours for a standard appeal after the decision has been made.

NOTICE OF BENEFIT DENIAL UPON APPEAL OR GRIEVANCE

The notice of the decision to continue to deny the requested benefit upon appeal or

grievance reconsideration will include the following:

1. The specific reason(s) for the appeal decision, in easily understandable language.
2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.
3. Notification that the Member, upon his or her request, can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.
4. Notification to the Member of his or her right to request from the plan, access to and copies of all documents relevant to the member's appeal, as the term "relevant" is defined in ERISA regulations §2560.503-1. "Relevant" documents include documents or records relied upon in making the appeal decision and documents and records submitted in the course of making the appeal decision.
5. A list of title and qualifications of individual(s) participating in the appeal review. Participant names do not need to be included in the written notification to members, but must be provided to members upon request. For adverse appeal decisions, upon the Member's request, the names of medical experts whose advice was obtained on behalf of the Plan in connection with the appeal, without regard to whether the advice was relied upon in making the appeal decision.
6. A description of the next level of appeal along with any relevant written procedures. If the appeal is at the final level of appeal within the Plan, the Member is supplied with the address of the Department of Labor and the Indiana Department of Insurance to which the Member can further their appeal, or the option to request an external review when a grievance is in regard to: (1) an adverse utilization review determination (2) an adverse determination of medical necessity or (3) a determination that a proposed service is experimental or investigational. An independent review organization (IRO) will be selected to review the case from a list of independent review organizations certified by the Indiana Department of Insurance. The plan will select a different IRO for each appeal, rotating the choice of an IRO among all certified independent review organizations before repeating a selection.at a cost of Twenty-five dollars ($25) to the Member. The Member must submit the $25 payment along with their request for external review.

SECTION VI. SUBROGATION AND REIMBURSEMENT

The intent of this Section VI is that if a Member (whether a Subscriber or a Dependent) is legally entitled to recovery from a third party for services paid for or provided by the Plan, then the Plan shall be entitled to reimbursement as a matter of first priority out of such recovery for the full amount of the Plan's benefit payments or the full value of the benefits provided to or on behalf of the Member. In other words, the Plan shall have the right to be reimbursed first and fully from any monies received by or on behalf of a Member as a recovery from a third party, with the balance, if any, retained by the Member.

The Plan's right of reimbursement under this provision exists without regard to whether the insured is made whole and without regard to how the recovery is characterized. For example, the Plan must be reimbursed even if the individual's recovery is characterized in a settlement or judgment as damages for pain and suffering or lost wages. In addition, the reimbursement to the Plan will not be reduced by the amount of any attorney fees paid by the individual as a percentage of the recovery (or by other means) unless applicable law requires such reduction, or the Plan has provided its written consent for the payment of fees prior to the fees being incurred by the Member.

The Plan may require the Member to enter into a repayment agreement as a condition for the Plan's payment of benefits to or on behalf of Members when the injury or illness to the Member occurs through the act or omission of another person. However, the Plan's right of reimbursement exists regardless whether such an agreement has been signed.

The Plan shall also have the right to enforce the terms of this clause by being subrogated to any action brought by the Member against a third party who may be responsible for payment of expenses or benefits provided to the Member by the Plan. In the event that the Member or a guardian on behalf of the Member declines to assert a claim to recover expenses from any third party to which the Member or his or her legal representative may be entitled, the Member shall assign or transfer to the Plan the Member's rights of recovery so that the Plan may assert its right of reimbursement or subrogation pursuant to this section against such third party.

The amount of reimbursement that the Plan shall be entitled to hereunder for items or services that are provided to the Member by health care providers where the Plan has paid for such services or items on a capitation or other non-fee-for-service basis shall be the usual and customary fees charged by the health care providers of such services or items without regard to the capitation or other arrangement, even if such providers are paid by a contractor to the Plan on a fee-for-service basis.

The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be made from funds the Member or his or her guardian or legal representative receives or is entitled to receive from a third party, or from any liability or other insurance covering the third party, or from any first party benefits such as uninsured motorist insurance, underinsured motorist insurance, or any medical payments coverage,

no-fault or school insurance coverages which are paid or payable.

The Plan shall have a lien on all funds recovered by the Member up to the amount that the Plan is entitled to recover hereunder. The Plan may give notice of that lien to any party who may have contributed to, or is responsible for the payment of, the loss.

Member agrees to cooperate fully with the Plan and shall provide any information requested by the Plan in a timely manner. The Member shall provide the Plan or its administrator notice in writing of any personal injury claim or any other claim for reimbursement of medical or disability expenses filed with any person or business entity within five days of filing such claim. The Member shall not settle or compromise any claim unless the Plan or its administrator is notified in writing at least thirty days before such settlement or compromise and agrees thereto in writing. The Member shall immediately repay the amount of any benefits the Plan has incurred.

SECTION VII. COORDINATION OF BENEFITS

A. **Purpose of Coordination of Benefits (COB):**

Members may have health coverage provided by more than one group health benefits plan at the same time. Each group health benefits plan has rules for Coordination of Benefits (COB) in the event of double coverage. These rules are designed to prevent the total amount of all the benefit payments from exceeding the cost of covered services.

B. **Benefits Subject to COB:**

All benefits provided under this Contract are subject to this Section. This COB provision applies to This Plan when a Member has health care coverage under more than one group healthy benefits plan.

The Member agrees to cooperate with This Plan in coordinating its obligations under this Contract with payment under any other group health benefits plan that covers the Member.

If the Member is covered by This Plan and another group benefits plan, the Order of Benefit Determination Rules described in Section D determine which plan is primary.

C. **Definitions For purposes of this Section (VII) only, the following terms will have the specified meaning(s):**

1. ***"plan":***

Any of these which provides benefits or services for, or because of, medical care or treatment:

(a) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident type coverage.

(b) Coverage under a governmental plan required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are in excess to those of any private insurance program or other non-governmental program.

(c) Fault and no fault automobile insurance whether group, group-type or individual. Each contract or other arrangement for coverage under (a), (b) or (c) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

2. ***"This Plan":***

The portion of this Contract which provides services or benefits that are subject to this provision.

3. ***"Primary Plan":***
When This Plan is a Primary Plan, its benefits are provided or paid without considering the other plan's benefits.

4. ***"Secondary Plan":***
When This Plan is a Secondary Plan, its benefits may be reduced and it may recover from the Primary Plan the reasonable cash value of the services provided by This Plan.

5. ***"Allowable Expense":***
The reasonable cash value for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made, less any applicable copayments due under This Plan.
When This Plan provides services, the reasonable cash value or equivalent cash value of each service is the Allowable Expense and is a covered benefit, less any applicable copayments, provided the following criteria are met:
(a) The service is not related to dental care.
(b) The Member complies with all provisions under this Contract.
(c) All services are considered coverable benefits under this Contract.

6. ***"Claim":***
A request that benefits of a plan be provided or paid.
The benefits claimed may be in the form of:
(a) Services (including supplies).
(b) Payment for all or a portion of expenses incurred.
(c) A combination of (a) and (b) above.
(d) An indemnification.

D. **Order of Benefit Determination Rules:**
1. When a Member receives services by or through This Plan (or is otherwise entitled to claim benefits from This Plan) and the services are also a basis for a claim under another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:
(a) The other plan has rules coordinating its benefits with those of This Plan; and
(b) Both the other plan's rules and This Plan's rules, in subparagraph 2. below, require that This Plan's benefits be determined before those of the other plan; or
(c) the other plan is a governmental plan and federal law requires This Plan to be the Primary Plan.

2. This Plan determines its order of benefits using the first of the following rules which applies.

(a) *Non-Dependent/Dependent:*
The benefits of the plan which covers the person as a Member (that is, other than as a Dependent) are Primary to those of the plan which covers the person as a Dependent.

(b) *Dependent Child/Parents Not Separated or Divorced:*
Except as stated in subsection 2.c below, when This Plan and another plan cover the same child as a Dependent of different persons, called "parents" (including when the parents of the child were never married) the following determine the order of benefits:

1. The plan of the parent whose birthday falls earlier in a year is Primary to the plan of the parent whose birthday falls later in that year; but
2. If both parents have the same birthday, the plan that covered a parent longer is primary.
3. If the other plan does not have the rule as described in 2.b.1 above, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(c) *Dependent Child/Separated or Divorced Parents:*
If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

1. First, the plan of the parent with custody of the child;
2. Then, the plan of the spouse of the parent with custody of the child; and
3. Finally, the plan of the parent not having custody of the child.

If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the plan obligated to pay or provide the benefits of that parent has actual knowledge of those terms, then that plan is Primary. The rules set forth in 2.c.1, 2.c.2 and 2.c.3 above shall be followed to determine the order of benefits if the parent appointed by the court to provide coverage for a child has failed to do so.

(d) *Joint Custody:*
If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in 2.b above.

(e) *Active/Inactive Employee:*
A plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) is Primary to a plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule 2.e is ignored.

(f) *Longer/Shorter Length of Coverage:*
If none of the above rules determines the order of benefits, the plan which covered a Member longer is Primary to the plan which covered that person for the shorter time. Two consecutive plans shall be treated as one plan if:

1. the claimant was eligible under the second plan within twenty-four (24) hours after the termination of the first plan; and if
2. there was a change in the amount or scope of a plan's benefits or there was a change in the entity paying, providing or administering plan benefits; or
3. there was a change from one type of plan to another (e.g., single employer to multiple employer plan).

(g) *Continuation Coverage:*
If an individual is covered under a continuation plan as a result of the purchase of coverage as provided under federal or state law, and also under another group plan, the following shall be the order of benefit determination:

1. First, the benefits of a plan covering the person as a Subscriber (or as that Subscriber's dependent)
2. Second, the benefits of coverage purchased under the continuation plan.

If the other plan does not have the rule described above and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

E. **Effect on the Benefits of This Plan:**

1. ***When This Section Applies:***
Section E applies when, in accordance with Section D, Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other plans. In that event, the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in paragraph 2 immediately below.

2. ***Reduction in This Plan's Benefits:***
If the Primary Plan payment is less than the charge for the covered service, then the Secondary Plan will apply its Allowable Expense to the unpaid

balance. Benefits payable under the other plans include the benefits that would have been payable if the Member had filed a claim for them.

3. ***When This Plan is the Secondary Plan:***
   (a) This Plan's benefits will be reduced so that they and the benefits payable under the other plans do not total more than the Allowable Expense.
   (b) The Member may be required to pay an amount which shall not exceed any applicable copayment required under This Plan.

F. **Right to Receive and Release Necessary Information:**

In order to decide if this COB Section (or any other plan's COB Section) applies to a claim, This Plan (without consent of or notice to any person) has the right to:

1. Release to any other person, insurance company or other organization any information, with respect to any person, which This Plan deems to be necessary claim information.
2. Obtain from any other person, insurance company or other organization any information, with respect to any person, which This Plan deems to be necessary claim information.
3. Require any person claiming benefits under this Contract to provide This Plan with any information needed by This Plan to coordinate benefits.

G. **Facility of Payment:**

Whenever payments which should have been made under This Plan in accordance with this provision have been made under any other plan, This Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under This Plan and, to the extent of such payments, This Plan shall be fully discharged from liability under this Contract.

H. **Right to Recover Payment:**

The benefits of This Plan shall not be reduced when, under the Order of Benefits Determination Rules, This Plan is the Primary Plan. However, benefits may be reduced or the reasonable cash value of any service provided by This Plan may be recovered from the Primary Plan, if This Plan is determined to be the Secondary Plan.

If the amount of benefit payment exceeds the amount needed to satisfy This Plan's obligation under this Section, This Plan has the right to recover the excess amount from one or more of the following:

1. Any persons to or for whom such payments were made.
2. Any group insurance companies or service plans.
3. Any other organization.

SECTION VIII. DOUBLE COVERAGE

A. **Workers' Compensation:**

No benefits will be provided under this Contract for services for which Workers' Compensation is the responsible payer. The benefits under this Contract for Members eligible for Workers' Compensation are not designed to duplicate any benefit to which such Members are eligible under the Workers' Compensation Law. In the event that benefits are provided under this Contract for services covered by Workers' Compensation, all sums payable for services provided hereunder to Members pursuant to Workers' Compensation are payable to and retained by the Plan. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation.

B. **Medicare:**

Except as otherwise required by applicable federal law, the benefits under this Contract for a Member who is enrolled in the Medicare program do not duplicate any benefit for which such Member is eligible under the Medicare Act, including Part B. To the extent that the Plan has duplicated such benefits, all sums payable under Medicare for services provided hereunder are payable to and retained by the Plan.

C. **Other Government Programs:**

Except as otherwise provided by applicable law that would require the Plan to be the primary payer, the benefits under this Contract shall not duplicate any benefits to which Members are entitled or for which they are eligible under any governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services provided hereunder are payable to and retained by the Plan.

D. **Member's Cooperation:**

Each Member shall complete and submit to the Plan such consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare or Workers' Compensation. The coverage of any Member who fails to so cooperate may be terminated in accordance with Section XIII.

SECTION IX. CONTINUATION OF COVERAGE

A. In the event a Member's coverage terminates while the Member is a registered bed patient in a Hospital, the Plan will provide continuation coverage for inpatient covered services until the earliest of the following occurs:

1. The Member's discharge from the Hospital.
2. Sixty (60) days pass after Arnett HMO terminates the contract.
   The Member obtains coverage from another plan that replaces this coverage provided by Arnett HMO.
3. The group agreement with Arnett HMO is terminated by a Group, as determined by:
   a. Written communication sent by the Group to Arnett HMO. The effective date will be at least fifteen (15) days after the date the written communication is placed in the United States mail or sent by facsimile transmission.
   b. The failure to pay a premium within the grace period permitted under the Contract.
4. Termination of a Member by Arnett HMO as stated in Section XIII.

B. If coverage for a member ends, the member may, dependent on his or her situation be eligible for coverage under the federal continuation of coverage provision or a health benefit plan under the conversion privilege provision.

1. **COBRA**

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), most employers with 20 or more employees sponsoring group health plans are required to offer employees or dependents a temporary extension of their health coverage at group rates in certain instances where coverage would otherwise end. Subscribers or dependents should contact the subscriber's employer for specific information regarding rights with respect to COBRA. Members enrolling under COBRA must continuously live in this Plan's Service Area and must meet all other eligibility requirements of this Contract while enrolled in the COBRA option.

2. **CONVERSION**

If the coverage of any Member terminates, provided COBRA regulations do not apply, he or she may be eligible to convert his/her membership to individual membership without furnishing evidence of insurability. Members are eligible to elect conversion coverage provided they have experienced a loss of coverage through their employer group because of:

- Subscriber's job loss or lay off;
- Subscriber's employer group is exempt from COBRA continuation coverage;
- COBRA benefits have been exhausted;
- Subscriber or subscriber's dependent loss of eligibility because of his/her age;
- The death or divorce of the Subscriber;

In order to obtain conversion membership, the Member must comply with the following:

(a) Submit a completed application for conversion to the Plan within thirty-one (31) days after the effective date of termination
(b) Submit premium payments required under such membership

Absent termination of a Member's coverage as provided in this Section, a Member shall not have the automatic right to convert to individual coverage. The Plan's conversion coverage may be different than coverage under this Contract, and shall be subject to the rules and provisions of the Plan which are in effect at the time application for such conversion is made.

Arnett HMO will not provide continuation of coverage under this Section if the Member terminates the Member's Contract.

SECTION X. RELATIONSHIPS AMONG PARTIES AFFECTED BY CONTRACT

The relationship between the Plan and Medical Physicians and Practitioners is an independent contractor relationship.

Physicians maintaining a physician patient relationship with Members are solely responsible to those Members for all professional services rendered by them. Practitioners maintain the hospital patient relationship with Members and are solely responsible to those Members for all supplied services. Neither Subscribers nor any eligible Dependents are the agent or representative of the Plan, and neither shall be liable for any acts or omissions of the Plan, its agents or employees, or of Medical Practitioners, or of any other person or organization with whom or with which the Plan has made, or hereafter shall make, arrangements for the provision of benefits and services under the Contract.

Participating Physicians and Practitioners are not agents of the Group or of Arnett HMO, and are not controlled by or acting on behalf of the Group or Arnett HMO. The Group and Arnett HMO shall not be liable for any acts or omissions of Participating Physicians or Practitioners.

SECTION XI. CONFIDENTIALITY OF RECORDS

The Plan is entitled to receive from any provider of services to any Member, information reasonably necessary in connection with the administration of this Contract but subject to all applicable confidentiality requirements. By accepting coverage under this Contract, the Member authorizes every provider rendering services hereunder to disclose all facts pertaining to such care and treatment and physical condition of the Member to the Plan upon request, and render reports pertaining to the same, and permit copying of records by the Plan. Information from medical records of Members and information received from Physicians or Practitioners incident to the physician-patient or practitioner-patient relationship shall be kept confidential, and except for use reasonably necessary in connection with the administration of this Contract, and to comply with government requirements established by law, may not be disclosed without the consent of the Member.

These confidentiality matters are covered by a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires that health plans protect the confidentiality of Members' private health information (the "Privacy Rule"). In addition, the Privacy Rule provides Members with certain rights with respect to their private health information. A complete description of how the Plan uses and discloses Members' private health information under the law and also a description of Members rights under HIPAA can be found in the Plan's Notice of Privacy Practices which was distributed to all existing Members in April 2003 and, subsequent to that date, is distributed to all new enrollees at the time of enrollment. A Member can also request a copy of the Notice by contacting the Plan's Member Services Department and/or by accessing the Plan's internet site at www.arnettplans.com.

SECTION XII. GENERAL PROVISIONS

A. **Non-Assignability:**

Assignment means the transfer to another person or to an organization of your right to the services provided under this Contract or your right to collect money from us for those services.

You cannot assign any benefits or monies due under this Contract to any person, corporation or other organization.

Any assignment by you will be void.

B. **Policies and Procedures:**

The Member must cooperate with the administrative policies, procedures and protocols of the Plan.

C. **Appropriate Language:**

In all references both in this Agreement and in any other document which shall be a part of the Contract, to any persons, parties, entities, organizations or corporations, the use of any particular gender or the plural or singular number is intended to include the appropriate gender or number.

D. **Responsibilities of the Member:**

1. The Member will notify the Plan of any change in name, address or marital status of Subscriber or any eligible dependents within ten (10) days of any such change.
2. The Member will notify the Plan immediately of any loss or theft of his identification card.
3. The Member will not allow any other person to use his identification card.
4. The Member will pay any applicable Cost Sharing at the time service is rendered or goods are received.
5. The Member will pay any charge resulting from missing a scheduled appointment without cancellation of such appointment.
6. The Member will notify the Plan of any other medical or health insurance coverage of the Subscriber or any eligible dependents within ten (10) days of acquiring such coverage.

E. **Identification Card:**

When a person becomes a Subscriber, he or she is issued an identification card listing all eligible dependents. This card should be presented when receiving services. The card(s) remain(s) the property of the Plan and may not be used once the Member is no longer eligible for benefits.

F. **Agreement to Terms of Agreement:**

By electing medical and hospital coverage pursuant to this Contract or accepting benefits hereunder, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions and provisions hereof.

G. **Circumstances Out of Plan's Control:**

In the event that due to circumstances not within the control of the Plan including, but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Practitioners' personnel or similar causes, the rendition of medical or hospital services provided under this Contract is delayed or rendered impractical, the Plan shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Participating Practitioners shall render hospital and medical services provided under this Contract insofar as practical, but the Plan and Participating Providers shall incur no liability or obligation for delay or failure to provide or arrange for services if such failure or delay is caused by such an event.

H. **Refusal of Recommended Treatment:**

Certain Members may, for personal reasons, refuse to accept procedures or treatment recommended by Practitioners. Practitioners may regard such refusal as incompatible with the continuance of a satisfactory Practitioners/patient relationship and their best efforts to render all necessary and appropriate professional services in a manner compatible with a member's wishes, insofar as this can be done consistently with the Practitioner's judgment regarding proper medical practice. If a Member refuses to follow a recommended treatment or procedure, then neither the Plan nor Participating Practitioners have any further responsibility to provide care for the condition under treatment, for so long as the Member refuses to follow the recommended treatment or procedure.

XIII. TERMINATION OF COVERAGE

A. **Termination of Benefits and Services:**

A member of the Group may be terminated as a Subscriber and/or a Dependent under this Contract for any of the following reasons:

1. Failure of the Group to remit to the Plan any applicable payment required to be made on behalf of a Member, in which event benefits and services shall terminate upon the expiration of the last prepaid period.

2. The coverage of any Member who ceases to be eligible under Section II shall terminate on the date eligibility ceased. Members may be eligible for a temporary extension of their health coverage at group rates through their employer under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Members may also be eligible for an individual conversion policy through the Plan, provided they meet all eligibility requirements. This paragraph also applies to Dependents of a Subscriber who has been terminated as an employee of the Group, for whatever reason, including the death of the Subscriber.

3. If any Cost Sharing required to be made by a Member is not received or arranged for within fifteen (15) days after service is rendered, the Plan may terminate such Member's benefits under the Contract upon fifteen (15) days written notice to Member.

4. The Member may terminate his or her participation in the Plan by providing written notice to the Plan ***in advance*** of the termination. Termination shall be effective as of the date agreed to by the Group and the Plan.

5. If, after reasonable efforts, a Participating Practitioner is unable to establish or maintain a satisfactory practitioner-patient relationship with a Member, coverage of the Member may be terminated upon thirty (30) days written notice. Examples of unsatisfactory practitioner-patient relationships include, but are not limited to, abusive or disruptive behavior in a physician's office, repeated refusals by the Member to comply with procedures or treatment plans recommended by a Participating Practitioner, and a Member securing services in a manner that impairs the ability of the Primary Care Physician to coordinate the Member's care.

6. A materially false or misleading statement or misrepresentation, as determined in the sole discretion of the Plan, by the Subscriber and/or his/her Dependents in application for membership. Regardless of the time of the discovery by the Plan, the Plan may, in its sole discretion, terminate the Subscriber's and/or his/her Dependents membership on a retroactive basis.

7. Member's behavior is disruptive, unruly, abusive or uncooperative to the extent that his or her continuing membership in the Plan seriously impairs the Plan's ability to furnish services to that Member or another Member.

8. A member commits or attempts to commit any fraudulent or dishonest act to obtain benefits to which, absent such acts, the Member would not be entitled.

9. Member fails to cooperate in the Plan's administration of the Subrogation, Coordination of Benefits, or Double Coverage procedures as described in Section's VI, VII and VIII, respectively.

Termination will cause all rights to benefits and services provided under this Contract to cease.

SECTION XIV. AMENDMENT

By this Contract, the Group makes coverage available to Employees who are eligible under Section II. However, this Contract shall be subject to amendment, modification, and termination by the Group without the consent or concurrence of any Subscribers. Subscribers and Dependents do not have a vested right in any Contract benefits. If the Contract is amended, changed, modified or terminated, Subscribers will not be vested in any further rights other than the provision of the benefits pursuant to the amended Contract, and the provision and/or payment for services covered under the prior Contract which was incurred prior to the amendment of the Contract.